Vision Plan of Marathon Oil Company

Effective: January 1, 2017
Group Number: 751924

Marathon Oil
Corporation

Vision Plan

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Section 1 — Welcome

Quick Reference Box

- Claims submittal address for Non-Network services: UnitedHealthcare Vision Claims Department, P.O. Box 30978, Salt Lake City, Utah 84130, Fax (248) 733-6060; and
- Online assistance for UnitedHealthcare Vision participating Provider list at www.myuhcvision.com or call (800) 839-3242 for the provider locator.
- Some Providers may refer to this Plan as Spectera, Inc. rather than UnitedHealthcare Vision.

Marathon Oil Company is pleased to provide you with this Summary Plan Description (SPD), which also serves as the Plan document and describes the vision Benefits available to you and your covered family members under the Vision Plan. It describes:

- who is eligible;
- services that are covered, called Covered Vision Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This document is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic document for this Plan.

Marathon Oil Company reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Plan document and SPD is not to be construed as a contract of or for employment.

UnitedHealthcare Vision is a private healthcare claims administrator. UnitedHealthcare Vision's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare Vision also helps to administer claims. Although UnitedHealthcare Vision will assist you in many ways, it does not guarantee any Benefits. The Plan, which is funded by employee contributions and Company contributions, is solely responsible for paying Benefits described in this document.

Please read this document thoroughly to learn how the Vision Plan of Marathon Oil Company works. If you have questions, contact the Marathon Oil Benefits Center.

How to Use This Document

- Read the entire SPD, and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.mrobenefits.com or request printed copies by contacting the Marathon Oil Benefits Center.
- Capitalized words in the SPD have specific meanings and are defined in Section 10, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 10, *Glossary*.
- Marathon Oil Company is also referred to as "the Company."

Section 2 — Introduction

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular part-time Employee who is scheduled to work at least 20 – 35 hours per week, or a regular full-time Employee who is scheduled to work at least 40 hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 10, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child provided that a court of competent jurisdiction has entered a final order for adoption prior to the date of your death, a child placed for adoption or a child, both of whose parents are deceased, for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you;
- your Domestic Partner and children of your Domestic Partner who reside with you and your Domestic Partner who, if they were your children, would meet the eligibility requirements above.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled in this Plan. In addition, if you and your Spouse are both covered under the Vision Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Vision Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 9, *Other Important Information*.

Cost of Coverage

The Plan is designed so that Marathon pays approximately 60% of the cost of the Plan and participants pay approximately 40% of the Plan cost through contributions. Your contribution amount depends on the family members you choose to enroll.

Contribution rates can be found by visiting www.mrobenefits.com or by calling 1-855-652-3067. Participants will be advised of changes in monthly contributions prior to the start of each calendar year.

How to Enroll

To enroll, call the Marathon Oil Benefits Center or visit www.mrobenefits.com to download an enrollment form. You must submit the form within 30 days of the date you first become eligible for Vision Plan coverage. If you do not enroll within 30 days, you must wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your vision election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must contact Marathon Oil Benefits Center within 31 days of the event. Otherwise, you must wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once the Marathon Oil Benefits Center receives your properly completed enrollment form, coverage will begin on your hire date if your completed election is received online or by Marathon Oil Benefits Center within 30 days of your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them by the deadline.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective on the date of marriage, provided you notify Marathon Oil Benefits Center within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Marathon Oil Benefits Center within 31 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or qualifying legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continue to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Marathon Oil Benefits Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Marathon Oil Benefits Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact the Marathon Oil Benefits Center within 31 days of the change in family status. Otherwise, you must wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Section 3 — How The Plan Works

What this section includes:

- Network and Non-Network Provider;
- Eligible Expenses; and
- Copayment.

Network and Non-Network Provider

When making an appointment, identify yourself as a UnitedHealthcare Vision member. The Network provider will also need the Employee's unique identification number or Social Security Number, and the patient's date of birth. The Network provider will contact UnitedHealthcare Vision to verify that you are eligible for service and materials.

At your appointment, the Network provider will provide a routine eye examination and determine if eyewear is necessary. The Network provider will itemize any non-covered charges. UnitedHealthcare Vision will pay the Network provider directly for covered services and materials.

You are responsible for paying the provider any applicable Copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a Network provider from UnitedHealthcare Vision's network assures direct payment to the provider for covered services, and helps to insure quality services and materials.

You may select a non-Network provider for services. However, your reimbursement schedule may not provide full payment, nor can UnitedHealthcare Vision help to insure patient satisfaction, when services are obtained from a non-Network provider. Refer to Section 7, *Claims Procedures* for details on how to file a claim and request reimbursement if you visit a non-Network provider.

Looking for a Network Provider?

You may access a listing of Network providers at www.myuhcvision.com. You may also call the Provider Locator Service at (800) 839-3242, enter your postal ZIP code and a list of Network providers will be provided.

Network Providers

UnitedHealthcare Vision arranges for vision providers to participate in a Network. Keep in mind, a provider's Network status may change. To verify a Provider's status, you can call UnitedHealthcare Vision or log onto www.myuhcvision.com.

Foreign Services

Foreign Services will be treated as Non-Network Benefits under this Plan. Payments will be made in U.S. currency and dispersed to the U.S. address of the Employee. The Company makes no guarantee on value of payment and will not protect against currency risk.

Eligible Expenses

Eligible Expenses are charges for Covered Vision Services that are provided while the Plan is in effect, determined according to the definition in Section 10, *Glossary*. Marathon Oil Company has delegated to UnitedHealthcare Vision the initial discretion and authority to decide whether a treatment or supply is a Covered Vision Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Maximum Non-Network Benefit

The Maximum Non-Network Benefit is the maximum amount the Plan will pay for a particular service.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Vision Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider.

Section 4 — Plan Highlights

The table below provides an overview of Copays that apply when you receive certain Covered Vision Services and outlines the Plan's frequency of service and Maximum Non-Network Benefit.

Service	Frequency of Service	Network Provider Copayment	Maximum Non-Network Benefit
Vision Exam	Once every 12 months	$10	$35
Frames	Once every 24 months[1]	$10[2,3]	$45
Lenses (Any one type)	Once every 12 months[1]		
• Single Vision		$10[2]	$25
• Bifocal Vision		$10[2]	$35
• Trifocal Vision		$10[2]	$45
• Lenticular Vision		$10[2]	$55
Contact Lenses	Once every 12 months		
• Elective Contact Lenses		$10 from the Covered Contact Lens Selection[4]	$105
• Necessary Contact Lenses		$20	$210

[1] You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

[2] If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copay will apply to those Eyeglass Lenses and Eyeglass Frames together.

[3] Eyeglass Frames will receive an allowance up to $120.

[4] You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of $105. No Copay will apply to non-selection Contact Lenses.

Section 5 — Additional Coverage Details

What this section includes:

- Covered Vision Services for which the Plan pays Benefits.

This section supplements the table in Section 4, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment information for each Covered Vision Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply. The Covered Vision Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 6, *Exclusions*.

Routine Vision Examination

The Plan pays Benefits for a routine vision examination of the condition of the eyes and principal vision functions according to the standards of care where the Covered Person resides, to include:

- a case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
- recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
- cover test at 20 feet and 16 inches (checks eye alignment);
- ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
- pupil responses (neurological integrity);
- external exam;
- internal exam;
- retinoscopy (when applicable) — objective refraction to determine lens power of corrective subjective refraction — to determine lens power of corrective lenses;
- phorometry/Binocular testing — far and near: how well eyes work as a team;
- tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
- tonometry, when indicated: test pressure in eye (glaucoma check);
- ophthalmoscopic examination of the internal eye;
- confrontation visual fields;
- biomicroscopy;
- color vision testing;
- diagnosis/prognosis; and
- specific recommendations.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

The Plan pays Benefits for lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

The Plan pays Benefits for a structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

- Keratoconus;
- Anisometropia;
- Irregular corneal/astigmatism;
- Aphakia;
- Facial deformity; or
- Corneal deformity.

Section 6 — Exclusions: What The Vision Plan Will Not Cover

What this section includes:

- Services, supplies and treatments that are not Covered Vision Services, except as may be specifically provided for in Section 5, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Vision Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Vision Service category in Section 4, *Plan Highlights*. Limits may also apply to some Covered Vision Services that fall under more than one Covered Vision Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when this document says "this includes," or "including but not limiting to," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, this document specifically states that the list "is limited to."

The following Services and Materials are excluded from coverage under the Plan:

1. non-prescription items;
2. medical or surgical treatment for eye disease, which requires the services of a Provider;
3. Services or Materials for which the patient is paid under Workers' Compensation Law, or other similar employer liability law;
4. Services or Materials which the patient, without cost, obtains from any governmental organization or program;
5. Services and Materials which are not specifically covered by the Plan;
6. replacement or repair of lenses and/or frames that have been lost or broken;
7. cosmetic extras, except as stated in the Plan Highlights section;
8. applicable sales tax charged on Services;
9. procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition;
10. any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency; and
11. missed appointment charges.

Section 7 — Claims Procedures

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Vision Services from a Network provider, UnitedHealthcare Vision will pay the Provider directly. If a Network provider incorrectly bills you for any Covered Vision Service other than your Copay, please contact the provider or call UnitedHealthcare Vision for assistance.

You are responsible for paying any Copay and expenses in excess of any Plan maximums owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Vision Services from a non-Network provider, you must pay the provider and then request reimbursement from UnitedHealthcare Vision through the claims process. Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt.

How to File Your Claim

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider):

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type and frame; and
- Send a copy of the itemized bill(s) to UnitedHealthcare Vision. The following information **must** also be included in your documentation:
  - Employee's name and mailing address;
  - Employee's unique identification number; and
  - Patient's name and date of birth.

If you choose a non-Network Provider, you must send your itemized receipts, with the Employee's unique identification number and the patient's name and date of birth to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
FAX: (248) 733-6060

Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Failure to provide all the information listed above may delay any reimbursement that may be due you.

After UnitedHealthcare Vision has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, UnitedHealthcare Vision may reasonably require that a Covered Person be examined at UnitedHealthcare Vision's expense by a Network Provider acceptable to the Company.

Explanation of Benefits (EOB)

You may receive an Explanation of Benefits (EOB) after processing of the claim. The EOB will inform you of any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can view and print all of your EOBs online at www.myuhcvision.com. See Section 10, *Glossary* for the definition of Explanation of Benefits.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare Vision to discuss the claim before requesting a formal appeal, but you are not required to do so in order to file a formal appeal. If UnitedHealthcare Vision cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. This communication should include:

- the patient's name and identification number;
- the date(s) of service(s);
- the provider's name;
- the reason you believe the claim should be paid; and
- any new information to support your request for claim payment.

UnitedHealthcare Vision will notify you of its decision regarding reconsideration of your complaint within 60 days of receiving it.

Appeals should be submitted to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Telephone inquiries concerning appeals should be made to: UnitedHealthcare Vision Claims, Appeals Department, 1-800-638-3120.

Section 8 — When Coverage Ends

What this section includes:

- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving treatment on that date.

When your coverage ends, Marathon Oil Company will still pay claims for Covered Vision Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for Services that you receive after coverage ended, even if the underlying condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the date you turn 65;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible; or
- the date UnitedHealthcare Vision receives written notice from Marathon Oil Company to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- the date you turn 65;
- the date your dependent turns 65;
- the date you stop making the required contributions;
- the date of the primary Member's death;
- the date UnitedHealthcare Vision receives written notice from Marathon Oil Company to end your coverage, or the date requested in the notice, if later; or
- the date your Spouse no longer qualifies as a Dependent under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to the staff of the Plan (including but not limited to employees of the Company whose work includes benefits administration), UnitedHealthcare Vision's staff, a provider or another Covered Person.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Plan, failure to pay required premiums, or acts of physical or verbal abuse.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by UnitedHealthcare Vision when coverage was provided in error, except where that error was made by UnitedHealthcare Vision.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Marathon Oil Company proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Marathon Oil Company's request, that the child continues to meet these conditions.

The proof might include medical examinations at Marathon Oil Company's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 10, *Glossary*.

Continuation Coverage Under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

Qualifying Events for Continuation Coverage Under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	**You May Elect COBRA:**		
	For Yourself	**For Your Spouse**	**For Your Child(ren)**
Your work hours are reduced	18 months	18 months[4]	18 months[4]
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months[3]	36 months[3]
You divorce (or legally separate)	N/A	36 months[3]	36 months[3]
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	18 months after qualifying event[4]	See spouse provisions
Marathon Oil Company files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months	36 months

[1] Subject to the following conditions: (i) the Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of COBRA continuation coverage; (ii) notice of the disability must be provided to the Plan Administrator within 60 days after the determination of the disability and before the end of the original 18-month maximum coverage period; (iii) the Qualified Beneficiary must agree to pay any applicable increase in the required premium for the additional 11 months over the original 18 months; and (iv) if the Qualified Beneficiary entitled to the 11 months of disability extension continuation coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] In the case of qualifying event that is a bankruptcy of the employer, a qualifying event includes a substantial elimination of coverage within one year before or after the date the bankruptcy proceeding commences for a covered Employee who had retired on or before the date of the substantial elimination of Plan coverage, or for any spouse, surviving spouse or dependent child of such individual if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse or dependent child is a beneficiary under the Plan.

[3] For individuals who are Qualified Beneficiaries covered for an 18-month or 29-month continuation coverage period, the original period is extended to 36 months for those individuals who are still Qualified Beneficiaries at the time of death or divorce.

[4] If a covered Employee becomes entitled to Medicare benefits before the occurrence of a qualifying event that is a termination of employment or a reduction of hours of employment, the maximum period of continuation coverage for a Qualified Beneficiary of such covered Employee will be the later of 18 months (or 29 months if there is disability extension) from the date of the qualifying event or 36 months of the date on which the covered Employee becomes entitled to Medicare benefits.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the vision Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Marathon Oil Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 11, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group vision Plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Section 9 — Other Important Information

What this section includes:

- Your relationship with the Plan;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Coordination of Benefits

Vision care Benefits will not be coordinated with those of any other health coverage plan. If you are a member of the Plan in the year you retire, any benefits received under the plan do not count toward benefits received under the Pre-65 Retiree Vision Plan.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order that instructs the Plan to cover your child, the Plan Administrator (or his or her delegate) will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship With the Plan

In order to make choices about your vision care coverage and treatment, it is important for you to understand how the Claims Administrator functions. The Claims Administrator does not provide services or make treatment decisions. This means:

- The Plan and UnitedHealthcare as Claims Administrator do not decide what care you need or will receive. You and your Provider make those decisions;
- UnitedHealthcare, as Claims Administrator, communicates to you decisions about whether the Plan will cover or pay for the vision care that you may receive (the Plan pays for Covered Vision Services, which are more fully described in this document); and
- The Plan may not pay for all treatments you or your Provider may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Plan Privacy and HIPAA

The Plan and UnitedHealthcare Vision may use individually identifiable protected health information (PHI) about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan and UnitedHealthcare Vision will use PHI to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operation and in research as permitted or required by law. The Plan and UnitedHealthcare Vision will use de-identified data for commercial purposes including research.

More information can be obtained regarding the use of PHI under HIPAA at www.mymarathonbenefits.com/common/docs/Privacy_Notice.pdf. The Marathon Oil Company Protected Health Information Policy is incorporated as part of this Plan document and identifies the privacy officer for purposes of HIPAA.

Relationship With Providers

The relationships between the Plan, UnitedHealthcare Vision and Network providers are solely contractual relationships. Network providers are not the Plan's or Marathon Oil Company's agents or employees or joint venturers, nor are they agents or employees or joint venturers of UnitedHealthcare Vision. Marathon Oil Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare Vision and any of its employees agents or employees of Network providers.

The Plan and UnitedHealthcare Vision do not provide vision services or supplies, nor do they practice medicine. Instead, the Plan and UnitedHealthcare Vision arrange for health care providers and pay benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare Vision's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. The Plan and UnitedHealthcare Vision are not liable for any act or omission of any provider.

The Plan Administrator is solely responsible for:

- enrollment (including the termination of your coverage); and
- notifying you of the termination or modifications to the Plan.

Your Relationship With Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Vision Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The Plan Administrator and UnitedHealthcare Vision have the sole and exclusive discretion to:

- interpret the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, and any Amendments; and
- make factual determinations related to the Plan and its Benefits.

The Plan Administrator and UnitedHealthcare Vision may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Information and Records

The Plan and UnitedHealthcare Vision may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Plan and UnitedHealthcare Vision may request additional information from you to decide your claim for Benefits. The Plan and UnitedHealthcare Vision will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan and UnitedHealthcare Vision with all information or copies of records relating to the services provided to you for which you are seeking Benefits under the Plan. The Plan and UnitedHealthcare Vision have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents.

The Plan and UnitedHealthcare Vision have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate review or quality assessment, or as the Plan is required to do by law or regulation.

For complete listings of your medical records or billing statements, the Plan recommends that you contact your care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request forms or records from UnitedHealthcare Vision, you also may be charged a reasonable fee to cover the costs of completing the forms or providing the records.

In some cases, the Plan Administrator and UnitedHealthcare Vision will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare Vision's designees have the same rights to this information as does UnitedHealthcare Vision or the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare Vision to promote the delivery of care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or

- a practice called "capitation," which is when a group of Network providers receives a monthly payment from UnitedHealthcare Vision for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's care is less than or more than the payment.

If you have any questions regarding financial incentives, you may contact UnitedHealthcare Vision. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision to participate is yours alone, but the Plan recommends that you discuss participating in such programs with your Provider. These incentives are not Benefits and do not alter or affect your Benefits.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Marathon Oil Company reserves the right to modify or terminate this Plan, in whole or in part, in such manner as it shall determine. Such modification or termination can be applied, at the sole discretion of Marathon Oil Company, to any or all types of Participants and their dependents. If the Plan should be terminated, this will not affect any claim for covered expenses incurred prior to the termination of the Plan.

Marathon Oil Company may exercise its reserved rights of amendment, modification or termination (i) by written resolution by the Board of Directors of Marathon Oil Company, (ii) by written resolution by the Executive Committee, (iii) by written actions exercised by any other Committee of the Board of Directors, for example the Salary and Benefits Committee, to which the Board of Directors of Marathon Oil Company or the Executive Committee of that Board has specifically delegated rights of amendment, modification or termination, or (iv) by written actions exercised by any other entity or person to which or to whom the Board of Directors of Marathon Oil Company or the Executive Committee has specifically delegated rights of amendment, modification or termination.

The Board of Directors of Marathon Oil Company or the Executive Committee has delegated to the Salary and Benefits Committee the authority to amend, modify, or terminate this plan at any time. This authority delegated to the Salary and Benefits Committee shall be exercised in writing.

In addition to other methods of amending the Plan which have been authorized, or may in the future be authorized, by the Marathon Oil Company Board of Directors, the Company's Vice President of Human Resources may (i) make technical amendments to the Plan, with the opinion of legal counsel, which are required by applicable laws and regulations; (ii) make amendments to the Plan, with the opinion of legal counsel, that are clarifications of Plan provisions; (iii) make amendments to the Plan in connection with a signed definitive agreement governing a merger, acquisition or divestiture such that the needed Plan changes are specifically described in the definitive agreement, or if not specifically described in the definitive agreement, the needed changes are in keeping with the intent of the definitive agreement; (iv) make amendments to the Plan in connection with changes that have a minimal cost impact (as described below) to the Company; and (v) make amendments to the Plan, with the opinion of legal counsel, in connection with changes resulting from state or federal legislative actions that have a minimal cost impact (as defined below) to the Company.

For purposes of "Modification and Discontinuance of Plan," "minimal cost impact" shall be defined as an annual cost impact to the Plan that does not exceed the greater of (i) and amount that is less than one half of one percent of the Plan's documented total costs, (total claims paid plus administrative costs) for the previous calendar year, or (ii) $500,000.

This authority delegated to the Company's Vice President of Human Resources shall be exercised in writing.

The Board of Directors of Marathon Oil Company or the Executive Committee has delegated to the Plan Administrator the authority to make amendments to this Plan as needed regarding any mandated changes evolving from regulations governing the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA).

Section 10 — Glossary

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum — any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any Amendments thereto shall apply to the Addendum.

Amendment — any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment is specifically changing.

Benefits — Plan payments for Covered Vision Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Claims Administrator — UnitedHealthcare Vision (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

COBRA — see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company — Marathon Oil Company.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) — a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) — the set dollar amount you are required to pay for certain Covered Vision Services as described in Section 3, *How the Plan Works*.

Covered Person — either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Covered Vision Services — including Services, or Materials, which the Claims Administrator determines to be:

- not provided solely for the convenience of the Covered Person, Provider, facility or any other person;
- included in Sections 4 and 5, *Plan Highlights* and *Additional Coverage Details*; and
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.

Covered Contact Lens Selection — a selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Dependent — an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Domestic Partner — an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
  - they have a single dedicated relationship of at least 6 – 18 months duration;
  - they have joint ownership of a residence; or
  - they have at least two of the following:
    - a joint ownership of an automobile;
    - a joint checking, bank or investment account;

- a joint credit account;
- a lease for a residence identifying both partners as tenants; or
- a will and/or life insurance policies which designate the other as primary beneficiary.

The Employee and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Marathon Oil Benefits Center upon your request.

Eligible Expenses — charges for Covered Vision Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based on:
Network Benefits	Contracted rates with the provider.
Non-Network Benefits	Billed amounts up to the Maximum Non-Network Benefit.

For certain Covered Vision Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines.

Employee — a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) — the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer — Marathon Oil Company.

EOB — see Explanation of Benefits (EOB).

ERISA — see Employee Retirement Income Security Act of 1974 (ERISA).

Explanation of Benefits (EOB) — a statement provided by UnitedHealthcare Vision to you, your Provider, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Foreign Services — services provided outside the U.S. and U.S. Territories.

Locations — means the offices of Network Providers.

Materials — means lenses, frames and contact lenses.

Maximum Non-Network Benefit — the maximum amount the Plan will pay for Benefits for a particular service. See the first table in Section 4, *Plan Highlights*, for the Maximum Non-Network Benefit amount.

Network — when used to describe a provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Vision Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Vision Services, but not all Covered Vision Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Vision Services and products included in the participation agreement, and a non-Network provider for other Covered Vision Services and products. The participation status of providers will change from time to time.

Network Benefits — description of how Benefits are paid for Covered Vision Services provided by Network Providers. Refer to Section 4, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits — description of how Benefits are paid for Covered Vision Services provided by non-Network providers. Refer to Section 4, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment — the period of time, determined by Marathon Oil Company, during which eligible Employees may enroll themselves and their Dependents under the Plan. Marathon Oil Company determines the period of time that is the Open Enrollment period.

Plan — The Vision Plan of Marathon Oil Company.

Plan Administrator — Deanna L. Jones. The Plan Administrator may from time to time appoint and delegate his authority to Assistant Plan Administrators.

Plan Sponsor — Marathon Oil Company.

Plan Year — a period of time beginning with the Plan anniversary date of any year and terminating exactly one year later. If the Plan anniversary date is February 29, such date will be considered to be February 28 in any year having no such date.

Provider — any optometrist, ophthalmologist, optician or other person who is properly licensed and qualified by law to provide Services.

Qualified Beneficiary — shall mean any individual who is entitled to continuation coverage under section 4980B of the Internal Revenue Code of 1986, as amended, including any individual who, on the day before a qualifying event (as described in Section 8, *Qualifying Events for Continuation Coverage Under COBRA*) is covered under the Plan and any child who is born to or placed for adoption with a Qualified Beneficiary during a period of continuation coverage.

Retired Employee — an Employee who retires while covered under the Health Plan.

Services — any covered benefit listed in Section 5, *Additional Coverage Details*.

Spouse — an individual to whom you are legally married or a Domestic Partner as defined in this section.

Section 11 — Important Administrative Information: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the vision Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 10, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Marathon Oil Company is the Plan Sponsor and Deanna L. Jones is the Plan Administrator of the Marathon Oil Company Vision Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator — Vision Plan
Marathon Oil Company
5555 San Felipe Street
Houston, TX 77056
(713) 296-4446

Claims Administrator

UnitedHealthcare Vision is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Plan Administrator may from time to time appoint and delegate his authority to Assistant Plan Administrators. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone or in writing at:

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Plan Administrator — Vision Plan
Marathon Oil Company
5555 San Felipe Street
Houston, TX 77056
(713) 296-4446

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Vision Plan of Marathon Oil Company
Plan Number:	530
Employer ID:	25-1410539
Plan Type:	Welfare benefits plan providing vision services and supplies
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured — administered in party by the Plan Sponsor and in party by various third-party claims administrators through administrative services only (ASO) contracts
Source of Plan Contributions:	Participants and Company
Source of Benefits:	The Plan is funded by contributions of Plan participants and the Company.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 7, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800)-998-7542.

The Plan's Benefits are administered by the Plan Administrator. UnitedHealthcare Vision is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare Vision and the Plan are not responsible for any decision you or your Dependents make to receive treatment, services or supplies from a provider. UnitedHealthcare Vision and the Plan are neither liable nor responsible for the treatment, services or supplies you receive from providers.

Marathon Oil Company has caused its name to be hereunto subscribed to by Deanna L. Jones, Vice President, Human Resources & Administrative Services Marathon Oil Company.

Marathon Oil Company

Deanna L. Jones
Vice President, Human Resources &
Administrative Services
Marathon Oil Company